U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 26Jun2002

In the Matter of:	:	
MARGARET JANNEY,o/b/o	:	Case No.: 1999-BTD-0006
FRANCIS R. JANNEY, decd.,	:	
Claimant,	:	
	:	
v.	:	
	:	
MILBURN COLLIERY COMPANY,	:	
Employer,	:	
	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,	:	
Party-in-Interest	:	

Randy Keefer, Executor for Francis R. Janney
For the Claimant

Mary Rich Maloy, Esq.
For the Employer

Elizabeth Lopes Beason
For the Director

Before: **Edward Terhune Miller**
Administrative Law Judge

DECISION AND ORDER-REJECTION OF CLAIM

This proceeding involves a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901 *et seq.* ("the Act"), and the regulations promulgated thereunder.[1] The Black Lung Benefits Act

[1]All applicable regulations which are cited are included in Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. The amendments to Part 718 *et al.*, published in Fed. Regis. Vol. 65, No. 245, Wednesday, Dec. 20, 2000, which became effective on January 19, 2001, are applicable in accordance with their terms in this case, which was pending on the effective date of the amended regulations. Director's Exhibits are denoted "D-," and Employer's Exhibits, "E-."

provides benefits to persons totally disabled due to pneumoconiosis or to survivors of persons who had pneumoconiosis and who were totally disabled at the time of death or whose death was caused by pneumoconiosis.

Procedural History

The Claimant-miner, Francis R. Janney (the "Miner"), filed a claim with the Office of Workers' Compensation Programs for medical benefits on December 13, 1979 (D-1). The Miner had previously been awarded federal black lung benefits by the Social Security Administration under Part B of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, for total disability from pneumoconiosis arising out of coal mine employment (D-3). On May 21, 1984, the District Director made an initial finding that the Miner was entitled to medical benefits under the Black Lung Benefits Act, and identified Milburn Colliery Company ("Employer") as the responsible operator that would be liable for any medical benefits due to the Miner (D-8). Employer initially contested the District Director's finding, but subsequently withdrew its controversion (D-9, 12, 13). An Award of Benefits was issued by the Deputy Commissioner on February 10, 1987 (D-14).

The Miner submitted various bills for medical treatment on October 12, 1994, April 7, 1995, September 25, 1995, and October 9, 1995 (D-29, 38, 40, 42). On February 6, 1996, an informal conference was held at which time the District Director found that Employer is liable for these bills (D-44). Employer challenged this finding (D-45, 46). The Trust Fund then accepted interim responsibility for the Miner's current and future medical bills in order to avoid having the Miner suffer financial hardship (D-44). Interim benefits were not paid from the Trust Fund for any previous medical expenses. Pursuant to Employer's February 9, 1996 request for a formal hearing, the case was transferred to the Office of Administrative Law Judges (D-45, 46). The Miner, who was hospitalized when this case was transmitted to the Office of Administrative Law Judges, died on April 8, 1996 (D-52). Consequently, the Miner had incurred additional medical expenses (D-52). The Employer requested, and the tribunal granted, a remand because additional medical bills were in dispute (D-48).

On remand, the District Director compiled a summary of all the outstanding medical bills that are in dispute in this case and made findings as to which medical expenses are reimbursable (D-63). According to the District Director's summary, the disputed medical bills fall into three groups:

> Group 1 - Bills submitted for the period of February 5, 1993 to May 7, 1993 for oxygen therapy, totaling $1,299.00, which the District Director found reimbursable.
>
> Group 2 - Bills submitted for oxygen equipment provided by Tamarack, Ltd. for the period of February 18, 1994 through August 9, 1995. The bill for providing oxygen for this period was $4,385.00. Although the District Director concluded that the medical treatment provided was compensable under the Act, he found that $4210.00 was

the appropriate reimbursement cost for such services.

Group 3 - Bills submitted for the Miner's emergency room visits and hospitalization. Included in this group are bills for an ambulance and emergency room visit on February 4, 1996. These bills actually totaled $807.00. The District Director found that the medical treatment was compensable under the Act. However, the District Director found that $539.32 was the appropriate reimbursement cost for the medical treatment offered, and the Trust Fund paid this amount. Also included in this group are bills for an ambulance and emergency room visit on February 24, 1996. The bills for this medical treatment again totaled $807.00. The District Director approved the medical treatment as compensable under the Act, but found that $539.32 was the proper reimbursement cost for the treatment provided, and the Trust Fund paid this amount. Lastly, there are bills for the Miner's hospitalization from February 24, 1996 until his death on April 8, 1996. Those bills totaled $98,218.96. The Trust Fund paid $88,098.36, but the District Director subsequently found that only $74,435.31 was reimbursable for that hospitalization, after discounting for medical treatment that was not related to the Miner's pneumoconiosis or ancillary pulmonary conditions.

The District Director determined that Employer is liable for payment of:

$75, 513.95 to the Trust Fund for bills paid after it refused to pay medical bills for the Miner and the Miner was put back on interim pay to avoid additional financial hardship.[2]

$3,429.00 to Claimant, Margaret Janney, the Miner's widow, as reimbursement for the medical services that the Miner paid for out of pocket in Groups 1 and 2.

$2,080.00 to Tamarack, Ltd. for the bills described in Groups 1 and 2 above that have not been paid.

(D-63, 64; Director's Closing Argument).

By letter dated February 25, 1999, Employer objected to the District Director's determination and requested a formal hearing, and so the case was transmitted to the Office of Administrative Law

[2] This total was arrived at by adding the reimbursable hospital expenses of $74,435.31 and the two charges of $539.32 for the two ambulance trips and emergency room visits. (Director's Closing Brief, amending D-63).

Judges (D-65, 66). By correspondence dated December 10, 1999 and January 13, 2000, this tribunal advised the representative of the deceased Miner's estate and other parties that a decision would be issued on the existing record in the absence of further communication from the parties. The Employer and Director acquiesced in the proposed course of action; however, this tribunal did not receive a response from the representative of the deceased Miner's estate, the Miner's widow, or any person representing them by the January 31, 2000, deadline set in the letter dated January 13, 2000. Accordingly, on February 7, 2000, this tribunal issued an Order Admitting Evidence into Record and Setting Briefing Schedule. Director's Exhibits one (1) through sixty-seven (67) and Employer's Exhibits one (1) through seven (7) were admitted into evidence. No evidence was separately submitted on behalf of the Miner. The parties were given until March 17, 2000 to submit written argument. Written arguments were timely submitted by the Director and the Employer.

Issues

1. Whether Employer is responsible for payment of $75,513.95 to the Trust Fund for medical bills paid?
2. Whether Employer is responsible for paying the survivors $3,429.00 for reimbursement of funds paid by the Miner for his oxygen equipment?
3. Whether Employer is responsible for payment of $2,080.00 to Tamarack, Ltd. for oxygen supplies not paid by the Miner, the Employer, or the Trust Fund.
4. Whether the Employer is liable for interest on the amounts due each party should reimbursement be required?

The findings of fact and conclusions of law are based upon analysis and review of the entire record, the arguments of counsel, and applicable statutes, regulations and case law. Each document admitted into evidence, whether or not mentioned, has been appropriately considered.

Medical Evidence and Breakdown of Treatment Costs Determined by the District Director to be Covered under the Act [3]

[3] Although their credentials are not of record, this tribunal takes judicial notice that the relevant qualifications of Drs. Cander, Subbaraya, Barnes, Khanna, Singh, Nazer, and Dy are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

There were three groups of medical bills as appropriately segregated by the District Director. The nature and justification of the treatments reflected in those bills were identified in assessments and opinions of Drs. Cander, Sherman, and Subbaraya, among others. The District Director relied upon the reasoned opinions of the three aforementioned doctors to support its position that Employer is liable for the costs of treatment. Accordingly, the opinions of Drs. Cander, Sherman, and Subbaraya are fittingly discussed in conjunction with the disputed medical bills.

Group 1 Medical Bills

The bills included in Group 1 were submitted for oxygen therapy from February 5, 1993 to May 7, 1993, and amounted to $1,299.00 (D-29 at 20-23). Accompanying these bills was a certificate of medical necessity from the Miner's treating physician, Dr. Subbaraya, board-certified in internal and cardiovascular medicine, recommending home oxygen for the Miner from February 5, 1993 through the remainder of his life. On the certificate of medical necessity, Dr. Subbaraya indicated that the Miner was hospitalized from January 25, 1993 through February 5, 1993 for "Acute exacerbation of COPD with marked hypoxemia, coronary heart disease, coal workers' pneumoconiosis." Dr. Subbaraya indicated that the oxygen was being prescribed for "COPD, CWP, acute exacerbation with marked hypoxemia." (D-29 at 15). Although the Miner continued on oxygen following May 7, 1993, Dr. Cander, board-certified in internal medicine, who reviewed these records for OWCP, determined that the use of portable oxygen could only be approved for three months, from February 5 through May 7, 1993, because the arterial blood gas study relied upon by Dr. Subbaraya in the certificate of medical necessity was obtained while the Miner was hospitalized (D-39).[4] Dr. Sherman, whose credentials could not be ascertained, also determined that oxygen ordered for this period should be reimbursed (D-58).

Group 2 Medical Bills

The bills included in Group 2 relate to oxygen equipment provided by Tamarack, Ltd. for the period of February 18, 1994 through August 9, 1995, which the District Director found to be reimbursable in the amount of $4,210.00 (D-29 at 40-52 , 38, 40). The oxygen was prescribed by Dr. Subbaraya, who prescribed home oxygen for the Miner from February 18, 1994 through the

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[4] In a letter to Employer which accompanied Dr. Cander's review of the disputed bills, a DOL Claims Examiner explained the following:

> The Department's procedures are such that we require a new CMN for every year, with a current ABG attached. If the initial period requested is based on a hospitalization and acute testing we approve only for 3 months, then the doctor must submit a new CMN with a non-acute ABG result to begin after the 3 month period ends for one year.

Dr. Cander referred to this Department standard in determining that the Miner was only entitled to the use of portable oxygen for three months following the January 27, 1993 ABG submitted in support of the February 5, 1993 CMN. (D-39).

remainder of life (D-29 at 3). Dr. Subbaraya relied upon an arterial blood gas test administered on February 18, 1994 in writing this prescription. This arterial blood gas test yielded a pCO_2 of 44 and a pO_2 of 43, which are qualifying results under both §727.203(a)(3) and Part 718 Appendix C[5]. (D-29 at 4). Dr. Subbaraya noted that pertinent diagnoses included COPD, coronary heart disease, and CWP (D-29 at 3). Dr. Cander initially questioned whether he could approve this medical treatment because Dr. Subbaraya utilized the incorrect certificate of medical necessity form (D-39). However, Dr. Sherman subsequently reviewed the prescribed treatment and found that is was reimbursable given the Miner's extremely low pO_2 (D-58).

Group 3 Medical Bills

This group of bills relates to the Miner's emergency room visits and hospitalizations. There are bills for an ambulance and emergency room visit on February 4, 1996 (D-52 at 80). In an opinion dated March 12, 1997, Dr. Sherman found that on this emergency room visit, the codes indicate that Miner was treated for respiratory failure and dyspnea, "manifestations of COPD and are therefore reimbursable." On the same page of that opinion, Dr. Sherman stated that the Miner's COPD is related, in part, to the Miner's coal dust exposure; however, he did not provide any rationale for this declaration. (D-56).

There are bills for an emergency room visit on February 24, 1996 (D-52 at 78-79 and 82). When he was admitted to the emergency room, the Miner's chief complaint was difficulty breathing. Dr. Barnes, board-certified in internal medicine, examined the Miner and prepared an emergency room note. The Miner reported a history of chronic obstructive pulmonary disease and possible congestive heart failure. Dr. Barnes noted the Miner reported not doing well for the past four days with increasing shortness of breath and increased swelling in his legs. The Miner did not describe increased cough or sputum production, nor did he describe chest pain, heaviness, or palpitations. (D-52 at 52-53). A portable chest x-ray was taken and compared to a film dated February 4, 1996. The x-ray revealed hyperaeration of the lungs, interstitial fibrotic thickening, and extensive pleural thickening blunting the left costophrenic angle. When compared to the previous chest x-ray, there was no significant change (D-52 at 74). An electrocardiogram showed poor R-wave progression in V1-V4, probable old anteroseptal myocardial infarction. Dr. Barnes's impression was: acute severe bronchitis with exacerbation of COPD and congestive heart failure. The Miner was admitted to the hospital (D-52 at 53). Dr. Sherman found that the Miner was treated for respiratory failure due to an acute exacerbation of COPD, a manifestation of coal workers' pneumoconiosis, and dyspnea during this emergency room visit. He found these medical expenses reimbursable. (D-56).

After arriving at the emergency room on February 24, 1996, the Miner was admitted to the hospital, where he remained until his death on April 8, 1996. The Miner's February 24, 1996 history and physical examination were taken and performed by Dr. Subbaraya. Dr. Subbaraya's impression was: acute exacerbation of COPD, coal workers' pneumoconiosis, coronary heart disease--old

[5] The criteria at Part 727, Subpart C, are applicable to claims for medical benefits cases, such as this case. §725.4(a) and (d).

anterolateral myocardial infarction, Zenker's diverticulum, and anemia of undetermined etiology (D-52 at 50-51). As stated by Dr. Subbaraya in the Miner's Discharge Summary, the Miner had a very complicated hospital course. The Miner was admitted with marked hypoxemia and hypercarbia. Dr. Subbaraya noted that once the Miner's hypokalemia was corrected, he was transferred from SICU to the stepdown unit on February 26, 1996. The Miner was then seen by Dr. Khanna, board-certified in internal medicine, hematology, and medical oncology, whose impression was: "mild normocytic anemia in elderly patient with a peripheral smear showing a dimorphic appearance of RBC." (D-52 at 56-57). Dr. Khanna performed a bone marrow aspiration which revealed normal iron stores (D-52 at 10). Based on the Miner's complaints of generalized weakness, greater in the lower limbs, physical therapy was consulted (D-52 at 10). The Miner was then seen by Dr. Singh, board-certified in surgery, on March 1, 1996, for consultation in regard to the Miner's inability to swallow due to a large esophageal diverticulum. (D-52 at 10 and 60-61). It was determined that when the Miner was strong enough, and had improved nutritionally, excision of the diverticulum would be considered. After consultation, Dr. Nazer, board-certified in internal medicine and the subspecialty of gastroenterology, attempted to perform an EGD and PEG on March 5, 1996; however, the procedure could not be done because the scope could not pass the diverticulum (D-52 at 10). On that same day, the Miner was in respiratory distress, and went into respiratory failure that evening when he was seen by Dr. Garretson, whose credentials could not be ascertained**.** Dr. Garretson transferred the Miner to the ICU where he was intubated and placed on a ventilator (D-52 at 10 and 58-59).

The Miner was weaned off the ventilator and "intermittently got slightly better and then worse." Among other things, he had poor appetite and could not eat, remained anemic, and developed edema of both upper limbs. Various medications and treatments were administered as outlined in the Discharge Summary. (D-52 at 10). A series of x-rays and an MRI were taken March 1, 1996, because the Miner was experiencing numbness in his hands and feet and had a possible compression fracture with cord compression. No evidence of a vertebral body fracture was seen, and the Miner was found to have well maintained dorsal and lumbar spines with some degenerative disc disease. (D-52 at 72-73). A March 8, 1996 bilateral lower extremity venous doppler examination showed no evidence of deep venous thrombosis (D-52 at 70).

On March 27, 1996, Dr. Singh performed a resection and repair of the Miner's diverticulum. In the Operative Record, Dr. Singh noted that the Miner had recurrent episodes of chest problems, possibly aspiration secondary to pharyngeal diverticulum. (D-52 at 62, 63). The Miner's post-surgical treatment is documented in his final discharge summary (D-52 at 11). On April 4, 1996, Dr. Dy, board-certified neurologist, diagnosed the Miner with Parkinson's disease, Class II-III, and paraparesis with specific cause to be investigated (D-52 at 54-55). Thereafter, it was determined that the Miner's condition was too poor for transfer to a nursing home, and, on April 8, 1996, Dr. Subbaraya noted there was a sudden change in the Miner's condition. The Miner developed brady arrhythmia with sinus bradycardia followed by junctional rhythm. Despite multiple resuscitation attempts, the Miner died. (D-52 at 11). The Miner's final discharge diagnoses were:

1. Acute exacerbation of chronic obstructive pulmonary disease
2. Chronic obstructive pulmonary disease

3. Chronic respiratory failure
4. Coal workers' pneumoconiosis
5. Congestive heart failure
6. Hypokalemia
7. Protein and calorie malnutrition
8. Coronary heart disease with old anteroseptal myocardial infarction
9. Anemia, etiology undetermined, may be due to chronic illness
10. Zenker's diverticulum to the esophagus
11. Parkinsonism

Dr. Sherman considered the Miner's February 24, 1996, emergency room visit and subsequent hospitalization "for an acute flare [up] of COPD to be reimbursable." Dr. Sherman based this determination on his finding that certain specified medical literature supports the existence of a causal relationship between coal dust exposure and chronic bronchitis and COPD. Dr. Sherman found that the Miner also received treatment during this hospitalization for anemia and a pharyngeal diverticulum, conditions he concluded were unrelated to chronic obstructive pulmonary disease, and therefore, not reimbursable (D-56, 62). Dr. Sherman utilized the Miner's final hospital bill to signal to the District Director which charges were and were not reimbursable. The total cost of the Miner's final hospitalization was $98,218.96. Dr. Sherman reviewed the services provided to the Miner during his hospitalization, which comprised over thirty-five photocopied pages, and placed an "NC" next to the charges that he "believed" were relevant to the Miner's anemia and pharyngeal diverticulum, and were, therefore, not covered. Dr. Sherman indicated in a separate letter that certain specific charges were either covered or not covered. Among non-covered charges were: room charges for the Miner's surgical procedure; medical/surgical supplies clearly associated with non-covered diagnoses; vanilla pudding apparently prescribed for the Miner's GI problem; video films apparently from an endoscopy, blood charges related to transfusion; and the spinal cord MRI. Of the $98,218.96, the Trust Fund paid $88,098.36, and based on Dr. Sherman's analysis, the District Director determined that $23,783.65 was not covered. Accordingly, based on Dr. Sherman's analysis, the District Director determined that $74,435.31 should be reimbursed by the Employer for the Miner's final hospitalization. (D-56, 62, 63).

Medical Opinions Based on Consideration of the Miner's Condition and the Disputed Medical Bills

Dr. Dahhan, board-certified in internal and pulmonary medicine and a NIOSH certified B-reader, reviewed for his March 20, 1996 report, prepared prior to the Miner's death to ascertain the necessity of the prescribed oxygen therapy under Groups 1 and 2, extensive medical evidence, including hospitalization notes and bills, dating from March 1986 through December 1995. (D-47). Dr. Dahhan concluded that the Miner's coronary artery disease with evidence of previous myocardial infarction, congestive heart failure, simple coal workers' pneumoconiosis Category I, and chronic obstructive lung disease caused the development of respiratory failure and frequent hospitalization. Dr. Dahhan opined that the Miner's simple coal workers' pneumoconiosis was not severe enough to have caused the amount of documented hypoxemia and respiratory insufficiency that required him to use oxygen on a regular basis, citing general medical literature in support of his conclusion. Dr.

Dahhan "suspected" that the Miner's severe hypoxemia resulted from his chronic obstructive lung disease and congestive heart failure. Accordingly, Dr. Dahhan recommended to the Employer, denial of payment for the Miner's portable oxygen concentrator system and the rental of his percusser, items also found by Dr. Cander to have no beneficial impact in the treatment of coal workers' pneumoconiosis or chronic obstructive lung disease, and therefore, not reimbursable under the Act.[6]

For his December 23, 1996, supplemental report, Dr. Dahhan reviewed his prior report in this case and the medical evidence and billing related to the Miner's final hospitalization. (D-54). Dr. Dahhan concluded that, while the Miner had simple coal workers' pneumoconiosis, his hospitalization was for the treatment of Zenker's diverticulum, anemia, pneumonia, and intermittent respiratory failure due to a combination of post-operative status, Parkinsonism and chronic obstructive lung disease. He concluded that the Miner's final demise was the result of refractory cardiac arrhythmia. Dr. Dahhan opined that the Miner's lengthy hospitalization was neither necessitated, nor aggravated, nor contributed to by the presence of simple coal workers' pneumoconiosis. He explained that simple coal workers' pneumoconiosis "does not produce this clinical picture, nor does it require placement on a mechanical ventilator, resection of part of the esophagus or placement on IV steroids or antibiotic therapy." Accordingly, Dr. Dahhan concluded that the Miner's treatment during his final hospitalization was not medically necessary for the treatment of coal workers' pneumoconiosis or any other pulmonary disorder arising from his coal mine employment.

Dr. Renn, board-certified in internal medicine and the subspecialty of pulmonary diseases, and a NIOSH certified B-reader, reviewed for his May 13, 1999 report extensive medical evidence dating from June 1986 through the Miner's final hospitalization in 1996. (E-1). Dr. Renn opined that, while

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[6] Dr. Cander stated the following in his April 19, 1995 report in regard to his denial of recommended payment for the oxygen concentrator and percussor:

> An oxygen concentrator supplied with an appropriate length of oxygen feed line to the patient permits the patient to travel throughout the home attached to the concentrator, thereby eliminating the need for a portable unit at home. Patients who require oxygen at home on a continuous basis, as a rule, have a limited capacity to travel outside of the home. In the absence of a satisfactory explanation, the oxygen utilization with the portable system seems excessive by any standard and I request quantitative data and calculations to justify the amount of oxygen requested for the portable unit during the period February 5, 1993 through September 18, 1994.
>
> There are no data or relevant clinical information to indicate the need for a percussor. In the practice of pulmonary medicine, the usual indication for a percussor is in the management of patients with cystic fibrosis of the pancreas to assist in the removal of viscid, purulent secretions. Furthermore, I am not aware of any directive in the DOL which approves the use of a percussor in the Federal Black Lung Program.

(D-39).

the Miner had simple coal workers' pneumoconiosis, his hospitalization of February 24, 1996, was not prompted by that disease, and, instead, was prompted by acute bronchitis and congestive heart failure. Dr. Renn also opined that the Miner's simple coal workers' pneumoconiosis was not a contributing factor to the multiple complications that occurred during his hospitalization. After listing well over a dozen medications and treatments received by the Miner during his hospitalization for various disease processes, Dr. Renn concluded that none of the therapies were for the benefit or relief of simple coal workers' pneumoconiosis.

Dr. Renn was deposed on July 15, 1999. (E-4). Dr. Renn explained that he utilizes a definition of coal workers' pneumoconiosis that includes the medical and broader definition that includes any respiratory disease process that either could be caused or aggravated by coal mine dust (E-4 at 4-5). Dr. Renn explained that the medical literature and his own experience indicate that simple coal workers' pneumoconiosis does not progress once the person is removed from further coal dust exposure; however, he noted that a loss in ventilatory function unrelated to the pneumoconiosis can occur. (E-4 at 5-6). Dr. Renn stated that, with the exception of experimental treatments, there is no known treatment for coal workers' pneumoconiosis (E-4 at 6-7). Dr. Renn reiterated that he had reviewed about a decade's worth of medical records and found that they revealed a series of diseases none of which were related to the Miner's coal dust exposure (E-4 at 8-9).

Dr. Renn explained that, when the Miner was found to have chronic obstructive pulmonary disease (COPD), it was a finding separate from the Miner's simple coal workers' pneumoconiosis, because Dr. Renn could not determine from the record how the Miner's doctor determined that he had "COPD possibly related to his coal workers' pneumoconiosis." Dr. Renn further explained that the records provided to him did not contain any ventilatory studies or evidence confirming that the Miner had "even been actually confirmed to have chronic obstructive pulmonary disease." (E-4 at 9-10). Dr. Renn stated that, while coal workers' pneumoconiosis has an obstructive component to it, coal workers' pneumoconiosis does not aggravate COPD (E-4 at 28-29). He explained that physiologic studies, which were unavailable for the Miner, can be used to determine how much of a person's COPD is due to coal workers' pneumoconiosis (E-4 at 29). Dr. Renn disagreed with the premise that any treatment for COPD would be related to pneumoconiosis because COPD is treated with bronchodilators and anti-inflammatory therapies, neither of which work for coal workers' pneumoconiosis because its obstructive component is irreversible and it is not an inflammatory process. (E-4 at 29-30).

Dr. Renn explained that the Miner's acute bronchitis for which he was admitted to the hospital on February 24, 1996, is usually viral and is a condition of the general population unrelated to or aggravated by coal workers' pneumoconiosis. He also opined that the Miner's acute bronchitis coupled with his compromised cardiac condition could have "tip[ped] him over" to congestive heart failure. (E-4 at 11; D-52 at 52-53). Dr. Renn explained, in great detail, how the individual treatments and medications the Miner received during his final hospitalization, which he specified in his previous report, were for disease processes unrelated to and unaffected by the Miner's coal workers' pneumoconiosis (E-4 at 11-21).

Dr. Renn opined that the Miner's use of oxygen during his lifetime was not necessary treatment or palliation for coal workers' pneumoconiosis because all the Miner's arterial blood gas studies were related to him being in the emergency room or being treated acutely for general cardiac failure, or for an infectious disease process of his respiratory tract that would have affected his blood oxygen. (E-4 at 21-22). Dr. Renn opined that the Miner's requirement for mechanical ventilation after the surgical procedure he underwent while in the hospital was caused by the surgery and not a pre-existing lung disease (D-3 at 24). Dr. Renn concluded that none of the medical bills he reviewed were for the treatment of any chronic dust disease of the lungs arising out of coal mine employment, or any ancillary pulmonary conditions arising from such a chronic dust disease of the lungs (E-4 at 27).

Dr. Spagnolo, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed for his June 19, 1999 report, extensive medical evidence dated from June 1986 through the Miner's final 1996 hospitalization. (E-2). Dr. Spagnolo concluded that none of the Miner's medications, hospital admissions, or chronic medical treatment and care during that period of time were for any medical problem that could in any way be related to his history of exposure to coal dust, and that the Miner's medical care and treatment were not for the treatment of pneumoconiosis or for a condition to which pneumoconiosis significantly contributed. In regard to the Miner's final hospitalization, Dr. Spagnolo opined that the Miner's symptoms and clinical findings "appear to have been precipitated by the enlargement of an esophageal diverticulum and a worsening of his heart failure," and concluded that the medical care and treatment that the Miner received , including all medications, were not for the treatment of pneumoconiosis or for a condition to which pneumoconiosis significantly contributed.

Dr. Spagnolo was deposed on August 3, 1999. (E-5). Dr. Spagnolo indicated that he had reviewed Dr. Castle's July 1, 1999 report and Dr. Renn's deposition transcript, and that he agreed with the conclusions of both physicians (E-5 at 11-12). Dr. Spagnolo explained that chronic obstructive pulmonary disease is: "a group of diseases that relate to the lung that result in obstruction to flow, air flow, measured in a laboratory as a -- by using pulmonary function tests, where flow is obstructed as one tries to expire air out of your lungs. So it's a group of diseases that have that in common." (E-5 at 17). Dr. Spagnolo explained that an acute exacerbation of COPD occurs when a patient's obstructive lung disease becomes unstable or symptomatic. Coal workers' pneumoconiosis, he explained, is a chronic lung disease, and, therefore, persons who have it do not develop acute exacerbations. (E-5 at 41-42). The Miner's final hospitalization was found by Dr. Spagnolo to be brought on by his heart failure as evidenced by the Miner's increased fluid retention (E-5 at 42). Dr. Spagnolo explained that on review of the medical records, it did not appear that any of the physicians were "extremely worried" about treating the Miner for COPD, especially because the record did not contain pulmonary function studies (E-5 at 28). He maintained that a "firm" diagnosis of COPD requires pulmonary function studies (E-5 at 29).

Dr. Spagnolo explained that the Miner was hospitalized on June 20, 1986 for a myocardial infarction which was unrelated to the Miner's exposure history to coal dust because myocardial infarction, a cardiac condition, occurs in the general population and has no relationship to coal

workers' pneumoconiosis (E-5 at 20). Dr. Spagnolo explained that the Miner's myocardial infarction was not one of the entities, like cor pulmonale, that involve the right side of the heart that may be related lung problems (E-5 at 20). Dr. Spagnolo explained that the Miner's June 28, 1986 hospitalization appeared to be for the same problem he had eight days prior, on June 20th, when the Miner had another myocardial infarction. Dr. Spagnolo clarified that when he stated in his original report that the "medications were not for a condition to which pneumoconiosis significantly contributed," he meant that pneumoconiosis was not contributing in any way to the condition for which treatment was being given. (E-5 at 21-22). Dr. Spagnolo indicated that the Miner's February 1993 hospitalization was for congestive heart failure. The Miner was treated at that time with bronchodilators, and Dr. Spagnolo opined that the treatment was not for coal workers' pneumoconiosis, but was for the Miner's wheezing. Dr. Spagnolo explained that in heart failure, people wheeze because fluid gets trapped around some of their airways, and that bronchodilators can dilate the airway. (E-5 at 23). Dr. Spagnolo concluded that the Miner's February 15, 1989 hospitalization was also for a cardiac condition (E-5 at 24). Dr. Spagnolo explained that a measurement of PaO_2 can be affected by either lung or heart disease, and that patients who have heart failure where fluid backs up into the lungs and interferes with lung function will have a decreased PaO_2. (E-5 at 26).

Dr. Spagnolo opined that the Miner was hospitalized on January 25, 1993, in January 1994, and in April and December 1995 for congestive heart failure which was more severe than he had previously exhibited (E-5 at 30-35 and 40). Dr. Spagnolo stated, "He doesn't appear to have ever gotten out of heart failure, and heart failure is a spectrum, you can be in heart failure, moderate heart failure, severe heart failure. And you can go from severe to moderate, or moderate to severe, and this can go on for a fairly long period of time." (E-5 at 35). Dr. Spagnolo explained that the Miner's October 1995 hospitalization was for an infection unrelated to his pneumoconiosis or heart disease (E-5 at 39-40).

Dr. Castle, board-certified in internal medicine and the subspecialty of pulmonary diseases and a NIOSH certified B-reader, reviewed for his July 1, 1999 report, extensive medical evidence dating back to 1986 and including recent reports from Drs. Cander, Dahhan, Sherman, Renn, and Spagnolo. (E-3). After a detailed discussion of each , Dr. Castle concluded that none of the therapies, drugs, hospitalizations, and other treatments including oxygen provided to the Miner from 1986 through 1996 were useful for, intended for, or appropriate for the treatment of coal workers' pneumoconiosis. He concluded that the various medical problems that the Miner suffered from were totally unrelated to his coal mine employment and dust exposure. Dr. Castle explained that, although the Miner had coal workers' pneumoconiosis, it did not cause him problems with coronary artery disease, congestive heart failure, acute bronchitis, bacterial pneumonia, esophageal diverticulum, anemia, malnutrition, and ultimately, postoperative respiratory failure. In regard to the Miner's final hospitalization, Dr. Castle opined that the hospitalization occurred as a result of congestive heart failure associated with acute bacterial bronchitis and exacerbation of COPD, and that the hospitalization was not related to or caused by coal workers' pneumoconiosis. None of the treatments rendered were directed toward, indicated for, or appropriate for coal workers' pneumoconiosis; the hospitalization and treatments were for numerous other medical conditions including coronary artery disease, congestive heart

failure, chronic obstructive pulmonary disease, acute bronchitis, anemia, esophageal diverticulum, postoperative respiratory failure, and Parkinson's disease. Dr. Castle indicated that oxygen therapy prescribed on February 5, 1993 was for an acute illness and that the arterial blood gases did not reflect the Miner's baseline status as an indication for oxygen therapy. He opined that the physician's certification of medical necessity for home oxygen therapy dated February 25, 1994 was related to acute episodes of chronic congestive heart failure.

Dr. Castle was deposed on November 15, 1999. (E-7). Since the preparation of his July 1999 report, Dr. Castle had reviewed a report by Dr. Fino and deposition transcripts from Drs. Renn and Spagnolo (E-7 at 9). Dr. Castle explained that the Miner's June 18, 1986 hospitalization was for acute myocardial infarction, congestive heart failure, and coronary artery disease, none of which are related to coal dust exposure (E-7 at 11-13). He emphasized that cor pulmonale is a heart condition that is due to lung disease that occurs in the absence of left heart disease, and is unassociated with the acute onset of chest pain. The Miner, Dr. Castle explained, did not have any findings to indicate the presence of cor pulmonale, noting that the Miner had left heart disease, and did not have the associated radiographic, EKG, and other changes associated with cor pulmonale. (E-7 at 13-16). Dr. Castle explained that the type of heart condition that the Miner had could have caused the observed symptoms of shortness of breath or dyspnea, stating:

> This kind of problem results in a reduction in function of the heart. When the heart does not function normally and then you stress the heart by exercising, then one of the conditions that you experience is dyspnea. That occurs because the blood is not pumped adequately around the body and the pressure in the heart builds up and this fluid backs up in the lungs. This increased fluid in the lungs then causes the sensation of dyspnea. That occurs very frequently with people that have coronary artery disease and congestive heart failure.

(E-7 at 17).

Based on review of a series of outpatient records from Dr. Subbaraya, Dr. Castle opined that he treated the Miner for a number of conditions including: follow-up to the Miner's 1986 myocardial infarctions, which resulted in a 100% blockage of the left anterior descending coronary artery; chest pain; evaluation for pulmonary embolus; heart failure; congestive heart failure; acute myocardial infarction; coronary artery disease; angina pectoris; bronchitis which was either viral or bacterial; dizziness; and abdominal pain. Dr. Castle noted that, during that time, the Miner never received any specific therapy directed towards coal workers' pneumoconiosis. (E-7 at 18-19). Dr. Castle explained that because the effects of industrial bronchitis do not persist after six months of ceased exposure to coal dust, and because bronchial asthma is totally unrelated to coal mine dust exposure, neither the bronchitis nor bronchial asthma for which the Miner was treated were caused by coal mine dust (E-7 at 19-20).

Dr. Castle opined that the Miner's February 13, 1989, February 18, 1989, February 2, 1993,

and April 17, 1995 hospitalizations were related to the Miner's worsening congestive heart failure and underlying cardiac disease. (E-7 at 21-25, 28-29). Dr. Castle explained that Dr. Subbaraya's prescription of an oxygen concentrator after hospitalization in February 1993 was not for coal workers' pneumoconiosis because the Miner was acutely ill at the time with congestive heart failure and possibly pneumonia. A single isolated blood gas or pO_2 of 33 at the time when someone is acutely ill, he explained, does not indicate that it is appropriate to send an individual home with an oxygen concentrator forever. Dr. Castle explained that persons who receive such oxygen based on an arterial blood gas test should be checked prior to leaving the hospital and then shortly thereafter to ensure that there is a chronic problem warranting the treatment. Dr. Castle then declared, "There is nothing in these records to indicate that this man [the Miner] had a chronic problem with a pO_2 that low. Since I know that he has CWP, if he had significant hypoxemia related to that, I would expect his pO_2 to be low all of the time and not just intermittently." (E-7 at 26-28).

Dr. Castle stated that the Miner's 1994 hospitalization for pneumonia was unrelated to his pneumoconiosis, which is unassociated with an increased incidence of any type of pneumonia (E-7 at 25-26). He found that the Miner's October 1995 hospitalization and treatment were due to a bacterium which grew out of his blood stream associated with pharyngitis, sore throat, inability to swallow, high fever, and chills, none of which was related to coal workers' pneumoconiosis (E-7 at 29-30). The Miner's hospitalization one and one-half months later for moderate congestive heart failure and an acute exacerbation of COPD was not an acute exacerbation of coal workers' pneumoconiosis. Dr. Castle explained that coal workers' pneumoconiosis does not acutely become worse or wax and wane, stating:

> Certainly, one can have airway obstruction that may be part of coal workers' pneumoconiosis, but it doesn't wax and wane without some other cause for that waxing and waning. In this case, if we look at what has happened here, we see that he has again some degree of hypoxemia. He is in heart failure and that will cause the findings that are associated with COPD. He did not respond to treatment for COPD, but he did respond to Lasix and treatment for his heart failure and coronary artery disease.

(E-7 at 30-31).

Dr. Castle reiterated the conclusion from his previous report that the Miner's final hospitalization in 1996 and death were unrelated to his coal workers' pneumoconiosis, stating:

> In my opinion, this man died as a result of complications from his surgery on his esophageal diverticulum, and the complications included cardiac arrest. He also had severe coronary heart disease with congestive heart failure that contributed to his death. His underlying CWP was quiescent and did not play a role in causing his death or causing these problems. He also had manifested during this time the malnutrition and anemia and these other problems [are]

associated with his postoperative respiratory failure.

(E-7 at 31-36).

Dr. Castle concluded that none of the certificates of medical necessity for home oxygen related to coal workers' pneumoconiosis, because the Miner's abnormality was not documented as chronic, but was apparently intermittent (E-7 at 37-38). In regard to the medications the Miner took during the ten year period from 1986 through 1996, Dr. Castle reiterated that none were for the treatment of coal workers' pneumoconiosis (E-7 at 38-39). When asked what types of medicines are used to treat persons with totally disabling pneumoconiosis, Dr. Castle explained that there is nothing very useful, but that if the patient has continuous hypoxemia related to that process, he would be treated with oxygen. He explained that, while bronchodilators are useful to those who have some reversible airways disease, they do not alleviate shortness of breath. Instead, they open up airways that can be reversibly dilated, and in doing so, they improve air flow and improve obstruction which may improve the degree of dyspnea, but would not relieve dyspnea. (E-7 at 40-41). While acknowledging the legal definition of pneumoconiosis, Dr. Castle opined that pneumoconiosis does not exacerbate COPD because they are two different disease processes with different impacts. In the Miner's case, Dr. Castle found that when his COPD was aggravated, it was aggravated by a bacterial process as opposed to a coal mining process. (E-7 at 41-43).

Dr. Fino, board-certified in internal medicine and the subspecialty of pulmonary diseases and a NIOSH certified B-reader, reviewed extensive evidence dating back to 1986 for his November 4, 1999 report. (E-6). Dr. Fino opened his report by explaining that he was aware that the Miner had been found totally disabled as a result of a coal mine dust related pulmonary condition, and that his definition of coal workers' pneumoconiosis is a lung disease caused by coal mine dust inhalation or a non-occupational lung disease that is aggravated by coal mine dust inhalation. Upon review of various hospitalizations, Dr. Fino concluded that the treatment received by the Miner was not reasonable or necessary for the palliation and/or treatment of a coal mine dust related pulmonary condition. He opined that the hospitalizations in February 1986 were for acute anteroseptal myocardial infarctions. Dr. Fino concluded that the Miner's February 1989 hospitalization was for acute bronchitis unrelated to coal workers' pneumoconiosis. He also noted that a February 7, 1989 chest x-ray indicated that the Miner had congestive heart failure. Dr. Fino concluded that the treatments that the Miner received during his February 1989 hospitalizations were unrelated to coal workers' pneumoconiosis, despite the listing of pneumoconiosis and chronic obstructive pulmonary disease as tertiary diagnoses. Dr. Fino concluded that the Miner was hospitalized in January 1994 for pneumonia and in April 1995 for chest pain, neither of which were related to or required treatment for coal workers' pneumoconiosis. He noted that an EKG performed during the Miner's April 1995 hospitalization did not provide evidence of cor pulmonale.

Dr. Fino explained that there were two hospitalizations in which the primary diagnosis was acute exacerbation of chronic obstructive pulmonary disease. While he acknowledged that obstruction can be seen in coal mine dust related lung disease, Dr. Fino stated that the medical literature indicates that obstruction which is severe is accompanied by severe fibrosis, as would be

expected with Category 3 or greater coal workers' pneumoconiosis. Dr. Fino explained that the degree of obstruction described and treated in the Miner during the two hospitalizations was not the type one would expect to see in a coal dust related lung condition and was not radiographically consistent with severe fibrosis. Additionally, Dr. Fino opined that if the Miner's coal dust related pulmonary condition were severe enough to result in hospitalizations, one would expect to find some evidence of right-sided heart failure, but the 1993 EKG evidenced none.

In regard to the other hospital bills, physician charges, and medical necessity forms, Dr. Fino noted that the primary emphasis was treatment of the Miner's coronary artery disease. In reviewing the blood gases, Dr. Fino noted that the Miner "certainly was sick and required oxygen." However, he also noted that there was an elevation in the Miner's carbon dioxide level, which is not seen in simple coal workers' pneumoconiosis, but may be seen in complicated disease. Dr. Fino concluded that, because blood gases do not get to the low level that requires oxygen in cases of simple coal workers' pneumoconiosis, none of the oxygen used by the Miner or any charges from Tamarack Ltd. were reasonable and necessary treatment for the palliation and/or treatment of a coal mine dust related pulmonary condition. Dr. Fino explained that he had reviewed reports from Drs. Renn, Castle, Spagnolo, Dahhan, Sherman and Cander. He disagreed with Dr. Cander's findings in his April 17, 1995 report, stating, "The oxygen that was used in this case was not for a coal mine dust related pulmonary condition. In fact, Dr. Cander referred to blood gases which showed an elevation in the carbon dioxide level. This is not seen in a coal mine dust related pulmonary condition." Dr. Fino agreed with Dr. Sherman's April 4, 1998 conclusion that the charges which he described were not reasonable and necessary for the treatment and/or palliation of a coal mine dust related pulmonary condition. Dr. Fino's report does not indicate that he reviewed the medical records related to the Miner's final hospitalization.

DISCUSSION

Under Section 11 of the Black Lung Benefits Reform Act of 1977, as implemented under §725.702, the Secretary of Health, Education and Welfare must notify each miner who received benefits under Part B of Title IV of the Act that he or she may file a claim for medical benefits.[7] In the case of a miner who was determined entitled to Part B benefits, and whose coal mine employment terminated on or after January 1, 1970, the Secretary is required to immediately authorize the payment of medical benefits and thereafter inform the responsible operator, if any, of the operator's right to contest the claimant's entitlement to medical benefits. §725.702(a) and (b)(2).

Pursuant to §725.701(b),

[7] The regulations at Parts 718 and 727 automatically provide compensation for medical treatment to miners who are found entitled to black lung benefits. However, there are no comparable provisions at Part 410 and §410.490, the regulations applicable to claims filed prior to April 1, 1980. As a result, Congress amended the Act to explicitly provide such benefits to miners whose claims were filed prior to April 1, 1980.

> A responsible operator, other employer, or where there is neither, the fund, shall furnish a miner entitled to benefits under this part with such medical, surgical and other attendance and treatment, nursing and hospital services, medicine and apparatus, and any other medical service or supply, for such periods as the nature of the miner's pneumoconiosis and ancillary pulmonary conditions and disability requires.

In order to qualify for medical benefits, a claimant must prove (1) that the mine operator should be held generally responsible for the miner's pneumoconiosis and (2) that the particular expense incurred was necessary to treat the miner's pneumoconiosis. *Doris Coal Company v. Director, OWCP* [Stiltner], 938 F.2d 492, 495, 15 BLR 2-135 (4th Cir. 1991). In this case, only the second issue is in question, i.e. whether the claimant's expenses were necessary to treat pneumoconiosis.[8]

The applicable law and regulations define pneumoconiosis as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." The definition is not confined to "clinical pneumoconiosis" as characterized by the permanent deposition of substantial amounts of particulate matter in the lungs and associated fibrotic reaction, but includes other diseases arising out of coal mine employment such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. Under the amended regulations, the definition pneumoconiosis specifically includes "legal pneumoconiosis," which includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment such a chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. §718.201(a). The term "arising out of coal mine employment" includes "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 30 U.S.C. § 902(b); §718.201(b). Moreover, pneumoconiosis can be latent and is recognized as a progressive disease. §718.201(c).

This broad definition "effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines." *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 14 BLR 2-68 at 2-78 (4th Cir. 1990) citing, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938, 2 BLR 2-38 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 BLR 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 BLR 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173, 19 BLR 2-265 (4th Cir. 1995).

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[8] An Administrative Law Judge does not have jurisdiction to order a responsible operator to reimburse the Trust Fund for a paid medical bill under 20 C.F.R. § 725.701, *et. seq.* Rather, the Administrative Law Judge must decide solely whether or not certain medical expenses are related to the treatment of pneumoconiosis. All collection actions and enforcement of liens are under the sole jurisdiction of the appropriate United States District Court. *Balaban v. Duquesne Light Co.*, 16 BLR 1-120 (1992); *Youghiogheny and Ohio Coal Co.*, 970 F.2d 161 (6th Cir. 1992).

Subsections 725.701(e) and (f) have been added under the amended regulations and essentially codify the formerly controlling *Doris Coal* presumption[9]:

> (e) If a miner receives a medical service or supply as described in this section, for any pulmonary disorder, there shall be a rebuttable presumption that the disorder is caused or aggravated by the miner's pneumoconiosis. The party liable for the payment of benefits may rebut the presumption by producing credible evidence that the medical service or supply provided was for a pulmonary disorder apart from those previously associated with the miner's disability, or was beyond that necessary to effectively treat a covered disorder, or was not for a pulmonary disorder at all.
>
> (f) Evidence that the miner does not have pneumoconiosis or is not totally disabled by pneumoconiosis arising out of coal mine employment is insufficient to defeat a request for coverage or any medical service or supply under this subpart. In determining whether treatment is compensable, the opinion of the miner's treating physician may be entitled to controlling weight pursuant to §718.104(d). A finding that a medical service or supply is not covered under this subpart shall not otherwise affect the miner's entitlement to benefits.

Although several opining physicians have reviewed medical evidence dating back to 1986, the relevant evidence relates to the medical bills conveniently grouped by the District Director into expenses for oxygen therapy received by the Miner for three months in 1993, and from February 1994 through August 1995, and for various treatments and therapies received by the Miner during his final emergency room visits and hospitalization. The Director's evidence on behalf of the Miner,

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[9] In *Doris Coal Co. v. Director, OWCP [Stiltner]*, 938 F.2d 492 (4th Cir. 1991), based on the broad definition of pneumoconiosis, the Court held that a miner meets his burden of showing that his medical expenses were necessary to treat pneumoconiosis if his treatment "relates to any pulmonary condition resulting from or substantially aggravated by the miner's pneumoconiosis." *Id.* at 496. The Court further held,

> Since most pulmonary disorders are going to be related or at least aggravated by the presence of pneumoconiosis, when a miner receives treatment for a pulmonary disorder, a presumption arises that the disorder was caused or at least aggravated by the miner's pneumoconiosis, making the employer liable for the medical costs.

Id. at 496-97. The Court also held, that, while the employer clearly has the right to challenge the necessity of certain medical charges for the treatment of a pneumoconiosis related disorder, or challenge medical charges not related to pneumoconiosis, an operator may not require a miner to prove again that he has pneumoconiosis each time he makes a claim for health benefits. *Id.*at 497.

consisting of the opinions of Drs. Subbaraya, Cander, and Sherman, is sufficient to invoke the §725.701(e) presumption in regard to the aforementioned charges. Dr. Subbaraya, the Miner's treating physician, recommended home oxygen for the Miner on February 5, 1993 through the remainder of his life for the Miner's "COPD, CWP, acute exacerbation with marked hypoxemia." (D-29 at 15). Despite Dr. Subbaraya's findings, reimbursement under the Act for the prescribed oxygen therapy was appropriately limited by Department of Labor procedures to a duration of three months as treatment for the Miner's pneumoconiosis because its need was based on an arterial blood gas study administered while the Miner was hospitalized (D-39).[10] Dr. Subbaraya again prescribed the Miner oxygen on February 18, 1994 for the remainder of his life based on an arterial blood gas test yielding disabling values and accompanied by diagnoses of COPD, coronary heart disease, and CWP (D-29 at 3). Dr. Sherman agreed with Dr. Subbaraya's finding based on the Miner's extremely low pO_2 (D-58). Dr. Cander questioned the approval of the treatment because Dr. Subbaraya utilized the incorrect form for its prescription (D-39). However, Dr. Sherman's and Dr. Subbaraya's finding of an extremely low pO_2 is sufficient objective evidence to require the prescription and therefore to invoke the §725.701(e) presumption, and this tribunal finds, as stated by Dr. Sherman, that the medical conclusion is not invalidated merely because a doctor fillet out the wrong form.

Dr. Sherman found that the Miner's February 4, 1996 emergency room visit was for treatment of manifestations of COPD related in part to the Miner's coal dust exposure (D-52 at 80; D-56). The Miner's February 24, 1996 emergency room visit was prompted by difficulty breathing, and led to what would be terminal hospitalization. The Miner was admitted with acute severe bronchitis with exacerbation of COPD and congestive heart failure. (D-52 at 53). Dr. Sherman, who reviewed the emergency room treatment notes, found that the Miner was treated for respiratory failure due to an acute exacerbation of COPD, a manifestation of coal workers' pneumoconiosis, and dyspnea (D-56). In regard to the Miner's subsequent lengthy hospitalization, Dr. Subbaraya noted that during that time, the Miner was diagnosed with, among other things, acute exacerbation of chronic obstructive pulmonary disease, chronic obstructive pulmonary disease, and coal workers' pneumoconiosis (D-52 at 8). Accordingly, Dr. Sherman found that the majority of the Miner's treatments, medications, and care in the hospital were for pulmonary disorders related to or aggravated by the Miner's pneumoconiosis. Because all of the aforementioned medical services/supplies, which comprise the bills described as Groups 1, 2, and 3, were found to be related to a pulmonary disorder, mainly COPD, the Miner is entitled to the rebuttable presumption that his COPD and exacerbations thereof, were caused or aggravated by his pneumoconiosis.

However, the §725.701(e) presumption invoked on behalf of the Director and the Miner only establishes the presumptive nexus between the Miner's pneumoconiosis and the disorder under treatment, which may be rebutted, and, as invocation shifts only the burden of production, not persuasion, the opinions of Drs. Subbaraya, Sherman, and Cander are subject to additional review. 65 Fed. Reg. 80,022 (Dec. 20, 2000); *see also Gulf & Western Indus. v. Ling*, 176 F.3d 226 (4th Cir.

[10] The application of the Department of Labor "procedures" as described by the Claims Examiner in her June 13, 1995 letter to Employer's attorney which accompanied Dr. Cander's April 17, 1995 report is unchallenged in this proceeding.

1999).[11]

Additionally, one of the means by which Employer may rebut the presumption is to produce credible evidence that the medical service or supply provided was for a pulmonary disorder apart from any of those previously associated with the Miner's disability. §725.701(e). The Department of Labor in this case, as in all cases under §725.702(b)(1), has accepted the Social Security Administration's finding of entitlement to medical benefits, and therefore, has assumed that the Miner in this case was totally disabled by pneumoconiosis. The Social Security Administration's findings are not of record and, when the Miner filed this claim in 1979, he indicated that the "award letter" was unavailable (D-1). Neither the Director nor the Employer submitted into the record any treatment records from Dr. Subbaraya (the Miner's alleged treating physician) other than hospital admissions, although several physicians purportedly reviewed them. Moreover, neither the Director nor the Employer sought Dr. Subbaraya's opinion in regard to the Miner's pneumoconiosis and treatment thereof, and there was no other source of record for such information. Accordingly, the evidentiary record is devoid of any evidence indicating the form(s) in which the Miner's pneumoconiosis manifested itself, and therefore, which "pulmonary disorders" were associated with his disability.

The physicians in this case assumed the Miner had pneumoconiosis and understood that the term "pneumoconiosis" describes numerous diseases apart from its strictly clinical manifestation. At issue is whether the Director's physicians, Drs. Sherman, Cander, and Subbaraya, correctly concluded that the Miner's chronic obstructive pulmonary disease (COPD) was a direct manifestation of his coal workers' pneumoconiosis. Employer's physicians, Drs. Dahhan, Castle, Renn, Spagnolo, and Fino, concluded that, if the Miner had COPD, of which there is no objective evidence of record, it was unrelated to his pneumoconiosis, and was likely related to his history of congestive heart failure. Therefore, Employer's physicians concluded that the Miner's documented history of oxygen therapy and various treatments for COPD and exacerbations thereof was really a documented history of treatment for congestive heart failure and associated heart disease.

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[11] The Fourth Circuit in *Gulf & Western Industries v. Ling*, 176 F.3d 226 (4th Cir. 1999), a precursor and model to amended §725.701(e), held the following in regard to the burden of persuasion in medical benefits only claims:

> Though the miner's burden of proving his claim is not onerous, it does not follow that it is nonexistent or that is has somehow been shifted to the employer or its insurer. If the party opposing the claim produces credible evidence that the treatment rendered is for a pulmonary disorder apart from those previously associated with the miner's disability, or is beyond that necessary to effectively treat a covered disorder, or is not for a pulmonary disorder at all, the mere existence of a medical bill, without more, shall not carry the day. The burden of persuading the fact finder of the validity of the claim remains at all times with the miner.

176 F.3d at 233.

This tribunal is so persuaded, having reviewed the evidentiary record against the opinions and the regulations. This tribunal accepts that the Miner had pneumoconiosis as defined in §718.201, as required of opining physicians, but does not accept that the Miner had coal dust related COPD rather than symptoms of chronic congestive heart failure, or that the Miner received treatment related to coal workers' pneumoconiosis, without the support of objective medical evidence. This tribunal recognizes, based on the evidence of record, that many of the disease processes described in relation to "legal" coal workers' pneumoconiosis are indistinguishable from other non-coal mine dust exposure related diseases, which, but for a proof of a causal connection to the miner's coal mine employment, would not be pneumoconiosis. In this connection, this tribunal finds that the opinions of Drs. Spagnolo, Castle, and Fino, and to a lesser extent those of Drs. Dahhan and Renn, are sufficient to rebut the opinions of Drs. Sherman, Cander, and Subbaraya, and the §725.701(e) presumption. Drs. Spagnolo, Castle, and Fino, all board-certified in internal medicine and pulmonary diseases, provided well-reasoned and well-documented opinions based on the evidence of record. On the other hand, Drs. Sherman, Subbaraya, and Cander are not so well qualified, in that none of these physicians is proved to be a board-certified pulmonary specialist. Dr. Cander is a board-certified internist only, Dr. Sherman's qualifications cannot be ascertained, and Dr. Subbaraya is a board-certified internist and cardiovascular specialist. Moreover, none of these three physicians provided reasoned opinions. Accordingly, this tribunal finds that the presumption has been rebutted, and that the Director, on behalf of the Miner, and the Black Lung Benefits Trust Fund, has failed to sustain its burden of persuasion.

Groups 1 and 2

With respect to the two groups of medical bills which purportedly relate to the Miner's requirement for oxygen therapy in 1993 and from 1994 to 1995, Dr. Subbaraya provided no basis or rationale for his determinations that the Miner was experiencing exacerbations of COPD and CWP, that there was a relation between the two identified conditions, or that there was a relation of the Miner's marked hypoxemia to his pneumoconiosis or COPD. Although Dr. Cander determined that the1993 prescription for oxygen therapy, which was based on an arterial blood gas study evidencing marked hypoxemia, was appropriate, he concluded that it was only appropriate for three months because Department procedures required repeated testing. (D-29 at 3-4 and 15, 39, 58). Dr. Cander did not assess the validity of the treatment for the Miner's pneumoconiosis or opine as to whether the Miner's reduced arterial blood gases were related to his pneumoconiosis. Dr. Cander also reviewed Dr. Subbaraya's 1994 prescription for oxygen therapy and found that, because it was submitted on the wrong form, the prescription was not accompanied by data necessary to determine the need for the requested equipment under the Federal Black Lung Program. Accordingly, Dr. Cander concluded that he could not approve the oxygen therapy. (D-39). He did not assess the validity of the treatment itself for the identified medical condition.

Dr. Sherman, who reviewed a certificate of medical necessity and a prescription for the two aforementioned prescriptions of oxygen therapy, concluded that oxygen therapy was required treatment for the Miner's pneumoconiosis because it was prescribed by Dr. Subbaraya for his COPD. Like Dr. Subbaraya's opinion, Dr. Sherman's opinion is unpersuasive because it is unaccompanied

by reasoning based on objective evidence linking the Miner's hypoxemia, which allegedly required the oxygen, to his COPD or his pneumoconiosis. Moreover, Dr. Sherman's unquestioning acceptance of Dr. Subbaraya's diagnosis of COPD without supportive objective physiological evidence, and Dr. Sherman's subsequent finding of a causal relationship between the Miner's COPD and his former coal mine dust exposure based on medical literature, rather than on the available evidentiary record, reflects an unquestioning adoption of the findings of other doctors whose opinions were also not explicitly reasoned in crucial, if not all, respects. (D-56).

Additionally, although Dr. Subbaraya had treated with unspecified frequency the Miner over an apparently significant but undefined period, his documented relationship with the Miner such as it is does not indicate that he ever, based either on personal examination or evaluation of the Miner's medical records, diagnosed the Miner with coal workers' pneumoconiosis or COPD. Instead, the records indicate that Dr. Subbaraya primarily treated the Miner for cardiovascular disease, rather than for respiratory or pulmonary conditions, noting in his reports only that the Miner was "known to have coal workers' pneumoconiosis" and "known to have severe COPD." (D-26, 52 at 50-51). Moreover, the types of testing and examinations conducted during the treatment relationship are for the most part undisclosed by the record. Accordingly, because the available records of Dr. Subbaraya's treatment only document, at the most, historical diagnoses of coal workers' pneumoconiosis and COPD, whose sources and reliability are wholly unknown, and, because those records neither document the physiological origins of those diagnoses or a relationship between the coal workers' pneumoconiosis and the COPD, this tribunal finds that Dr. Subbaraya's opinion lacks the indicia of credibility which would entitle it to controlling weight as the opinion of a treating physician, particularly with respect to any relationship between diagnosis or treatment related to pulmonary disease affected by coal mine dust or coal workers' pneumoconiosis.

Not only is there a lack of affirmative evidence in support of the Miner's need for oxygen therapy for the treatment or palliation of his pneumoconiosis, but the material evidence indicates that the oxygen therapy was used to treat the Miner's chronic congestive heart failure, a medical condition unrelated to his pneumoconiosis or COPD related to his pneumoconiosis. Drs. Spagnolo, Castle, and Fino, all board-certified in internal medicine and the subspecialty of pulmonary diseases, provided well-reasoned and documented opinions based on explicit review of extensive medical evidence that the Miner's oxygen therapy was not required by the COPD, which if anything, they opined, was indicated by the Miner's treating physicians to be mild. Dr. Castle concluded that it was the Miner's chronic congestive heart failure, which caused both hypoxemia and symptoms indistinguishable from those of COPD, which required the prescribed oxygen therapy. Dr. Spagnolo's opinion corroborates that of Dr. Castle in that he was skeptical of the Miner's historic diagnosis of COPD due to the nonexistence within the record of supportive physiological evidence. Dr. Fino, though accepting a COPD diagnosis, also questioned its relationship to the Miner's pneumoconiosis in light of the available objective evidence, and, therefore, his opinion corroborates those of Drs. Castle and Spagnolo. Dr. Castle's plausible explanation for the Miner's need for oxygen therapy, as supported by the opinions of Drs. Spagnolo and Fino, is persuasive because these three physicians critically analyzed the evidence of record, including its deficiencies, and, based on the objective evidence of the Miner's condition and his clinical course with various physicians as disclosed by the record,

provided well-reasoned and intrinsically corroborative opinions. Accordingly, their opinions are persuasive.

Drs. Dahhan and Renn, both board-certified in internal medicine and the subspecialty of pulmonary diseases, also concluded that the Miner's oxygen therapy was not necessary for the treatment or palliation of his pneumoconiosis. However, these physicians' opinions contain defects in reasoning that require this tribunal to consider them with caution and ascribe probative value accordingly. Though somewhat corroborative of the opinions of Drs. Spagnolo, Fino, and Castle, in that he opined that the Miner's severe hypoxemia resulted from chronic obstructive lung disease and congestive heart failure unrelated to and as opposed to pneumoconiosis, Dr. Dahhan's opinion is equivocal and limited by its reliance on a diagnosis of clinical pneumoconiosis that is not supported by radiographic or other objective evidence of record. Dr. Dahhan provided no rationale reconciling why he found explicitly that the Miner's simple coal workers' pneumoconiosis was severe enough to contribute to respiratory failure, but at the same time, not so severe that it required oxygen therapy. Furthermore, without explanation, Dr. Dahhan defined the Miner's pneumoconiosis as Category I simple coal workers' pneumoconiosis. As earlier explained, the record is devoid of any indication as to the form(s) of pneumoconiosis present in the Miner, and therefore, because Dr. Dahhan proffered no objective evidence in support of a diagnosis of Category I simple coal workers' pneumoconiosis, which would presumably consist of a x-ray interpretation, his finding in that regard is unreasoned and unpersuasive. Accordingly, because his opinion is equivocal, unreasoned and assumes without an objective evidentiary basis that the Miner had clinical pneumoconiosis only, Dr. Dahhan's opinion is of less probative value. (D-47).

Dr. Renn also concluded in a well-reasoned opinion, and in agreement with Drs. Castle and Spagnolo, that the Miner's use of oxygen during his lifetime was not a necessary treatment or palliation for his coal worker's pneumoconiosis because the evidence of record indicated that oxygen therapy was required by the Miner's chronic congestive heart failure and that the evidentiary record did not support a diagnosis of COPD or pneumoconiosis related COPD (E-4 at 9-10, 21-22, 29-30). However, during his deposition, Dr. Renn stated that simple coal workers' pneumoconiosis does not progress once the person is removed from further coal dust exposure (E-4 at 5-6). This statement directly conflicts with the Act's recognition in §718.201(c) that pneumoconiosis can be a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure. Therefore, while this tribunal accords Dr. Renn's opinion some weight to the extent that it is consistent with Drs. Castle's and Spagnolo's findings, it finds Dr. Renn's credibility weakened by his characterization of the nature of pneumoconiosis. Therefore, his opinion is not entitled to significant weight.

In this case, the Director has produced as proof of medical costs related to coal workers' pneumoconiosis little more than a medical bill for the Miner's oxygen therapy. Dr. Sherman's unreasoned assumption that the Miner had COPD of such severity that it required continuous oxygen therapy, and that such COPD was associated with the Miner's disabling pneumoconiosis, does not establish that the oxygen therapy was necessitated by the Miner's totally disabling pneumoconiosis. Moreover, the well-reasoned opinions of Drs. Spagnolo, Castle, and Fino, who are credentialed in

pulmonary medicine, and who discussed in detail and utilized the objective evidence of record, demonstrate that the Miner's need for oxygen therapy was primarily rooted in his chronic congestive heart failure, the symptoms of which produced a clinical picture apparently interchangeable with that of COPD. And, although Dr. Subbaraya's treatment of the Miner is undocumented, the evidentiary record contains Health Insurance Claim Forms dated from February 1993 through August 1995, which indicate that the Miner carried diagnoses from Dr. Subbaraya of congestive heart failure and hypoxemia separate and apart from diagnoses of chronic obstructive pulmonary disease and coal workers' pneumoconiosis (D-29 at 20-53; D-40). Also, in February 1994, the diagnosis of coal worker's pneumoconiosis disappears from the forms despite its character as an incurable and progressive disease, and is replaced by chronic ischemia, which Dr. Castle defined as decreased or inadequate blood flow to the heart (D-29 at 40-53; D-40; E-7 at 18). Though unaccompanied by objective medical evidence, these Claim Forms document the Miner's ongoing struggle with congestive heart failure, and suggest that the Miner's coal workers' pneumoconiosis was initially considered separate from the his chronic obstructive pulmonary disease.[12] Therefore, this tribunal finds that the bills in Group 1 and Group 2 are not reimbursable under the Act and Employer is not responsible for their payment.[13]

Group 3

The Director has also failed to carry its burden of persuasion with regard to the reasons for emergency room visits and hospitalization related expenses in this group.[14] Dr. Sherman's conclusion that the Miner's February 4, 1996 emergency room visit was for treatment of manifestations of COPD related to the Miner's former coal dust exposure is neither supported by objective evidence nor accompanied by a rationale. In fact, the health insurance claim form of record indicates that the Miner was seen for shortness of breath, chest pain, "abdominal," and stroke/CVA. (D-52 at 80). Dr. Sherman's review of the Miner's February 24, 1996 emergency room visit and subsequent terminal hospitalization is too short to be probative. After reviewing the Miner's final discharge summary and thirty-five pages of medical bills related to that hospitalization, Dr. Sherman summarily determined that only specific charges related to the Miner's anemia and pharyngeal diverticulum were unrelated to the Miner's pneumoconiosis. For the remaining charges, Dr. Sherman stated that the hospitalization for an acute exacerbation of COPD were reimbursable, but provided

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[12] There is no evidence of record indicating why Dr. Subbaraya ceased recording a diagnosis of coal workers' pneumoconiosis on the Health Insurance Claim Forms.

[13] Though well-reasoned and persuasive, Dr. Fino's opinion only ruled out a coal mine dust related pulmonary condition as the cause of the Miner's need for oxygen, and did not suggest an alternative etiologic factor. Because this tribunal considered Drs. Dahhan and Renn flawed in their reasoning, it did not rely on their conclusions, nor did it need to, in light of the other opinions of record.

[14] Dr. Cander did not provide an opinion in regard to the Miner's emergency room visits or final hospitalization. Dr. Subbaraya prepared the Miner's final discharge summary and performed his initial history and medical examination. He only documented the Miner's hospital course and did not provide an opinion with regard to the medical billing for the Miner's treatment

no reasoning in support of the conclusion that the Miner was hospitalized primarily for COPD or that such COPD was a manifestation of the Miner's pneumoconiosis. (D-56). When asked for further clarification, Dr. Sherman simply referred to the medical bills indicating which charges he "believed" were related to the Miner's uncovered "GI and hematologic problems." No additional reasoning appears within the submitted medical bill unsystematically marked with "NC's" by Dr. Sherman. Although Dr. Sherman did specifically list some charges that he felt were unrelated to the Miner's pneumoconiosis and provided brief explanations as to why they were not covered, he failed to elaborate upon any of the numerous charges he determined were related to the Miner's pneumoconiosis. Accordingly, this tribunal finds that neither objective evidence nor a reasoned opinion proves that the extensive medical bill for the Miner's final hospitalization of over $70,000 reflects charges for pneumoconiosis related treatment. Dr. Sherman's evaluation of that bill does not qualify as such proof.

Since the opinions of Drs. Dahhan and Renn are flawed, and because Dr. Fino apparently did not review the records of the Miner's final hospitalization, this tribunal relies primarily upon the opinions of Dr. Spagnolo and Dr. Castle to resolve the issue of Employer's liability for such medical bills. In well-reasoned opinions based on thorough review of the Miner's course of treatment during his final hospital admission, Drs. Spagnolo and Castle concluded in corroborating opinions that the Miner's final hospitalization occurred as a result of his worsening congestive heart failure, acute bacterial bronchitis, and esophageal diverticulum, and that none of the medical care he received was for treatment or palliation of pneumoconiosis or a condition to which pneumoconiosis contributed. (E-2, E-3, E-5 at 42-43, E-7 at 17, 30-31). Because Drs. Spagnolo and Castle critically considered each treatment received by the Miner during his hospital course in conjunction with his documented history of chronic congestive heart failure and its associated symptoms in forming their opinions, and because neither physicians' opinion was limited to consideration of the Miner's actual treatment, but clearly evinced explicit examination and evaluation of the Miner's underlying medical conditions and the appropriateness of the prescribed clinical courses, their well-

reasoned opinions persuade this tribunal that none of the Miner's final hospitalization was required by his pneumoconiosis. Therefore, Director has not carried its burden of persuasion that the Miner's final hospitalization was necessitated by or included any treatments related to his pneumoconiosis. The production by Employer of reasoned medical opinions indicating that the Miner's history of chronic congestive heart failure necessitated the initial need for hospitalization, and that other disease processes completely unrelated to the Miner's pneumoconiosis also caused that hospitalization to end with the Miner's death. Consequently, this tribunal finds that Employer has rebutted the presumption under §725.701(e) that any of the final hospitalization charges were related to the treatment or palliation of the Miner's coal workers' pneumoconiosis, and so the Employer should not be liable for them.

Although neither Dr. Spagnolo nor Dr. Castle addressed the Miner's February 4, 1996 emergency room visit, Dr. Sherman's evaluation of the relevant evidence did not persuade this court that the Miner's hospitalization was in any way related to his pneumoconiosis. It follows that the Employer is not liable for the costs of that emergency room visit, or any of the other claimed medical

costs.

ENTITLEMENT

The Director, on behalf of the Miner and the Black Lung Benefits Trust Fund, submitted evidence sufficient to invoke the §725.701(e) presumption that prescribed oxygen therapy and hospitalizations, categorized in groups 1, 2 and 3, were reimbursable under the Act. However, by failing to proffer a well-reasoned opinions from either the Miner's treating physician, Dr. Sherman, Dr. Cander, or any other appropriately qualified source, and instead submitting pages of highlighted hospital charges and reports that focus on legally immaterial or vague and unenlightening data, the Director failed to sustain its burden of persuasion. Employer, on the other hand, adduced reasoned opinions of five board-certified internists and pulmonary specialists based on a decade's span of medical information. Although the reasoning of two of those physicians was clouded by presumptions which conflict with the Act, the well-reasoned and detailed opinions of Drs. Spagnolo and Dr. Castle, and to a lesser extent, Dr. Fino, provide ample evidence to rebut the §725.701(e) presumption with objective evidence of record. Ten years of medical records proved to the opining physicians and to this tribunal that the Miner's congestive heart failure was the predominant factor in his pulmonary disability, and that the pulmonary conditions for which the Miner was treated were unrelated to his pneumoconiosis. Consequently, none of the bills in Groups 1, 2, and 3 are reimbursable under the Act.

ORDER

The claim for reimbursement under the Act for the medical care and supplies provided to the Miner, Francis Janney is denied.

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EDWARD TERHUNE MILLER
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any interested party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a notice of appeal with the **Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of the notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.